Honoring Choices My Health Care Goals

Completing a health care directive is an important step in making sure your loved ones and health care providers understand your values and choices for health care treatment if you are not able to speak for yourself. To help you think about how different circumstances might affect your health care goals and choices, complete the following worksheet. We encourage you to discuss these questions and answers with your health care agents and your loved ones. You may also wish to attach this document to a newly created health care directive (you cannot make additions to an already completed directive). Please add your name and the date completed at the bottom of each page.

What would you like to accomplish in the process of advance care planning and/or in completing a health care directive?

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Are there situations you have had or heard about where a decision needed to be made about a critical health care situation? If so, were there things you would want or not want done for you?

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What and/or who makes life worth living to you or sustains you in difficult situations?

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Are there any fears or worries you have about current or future medical care?

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Your religious or spiritual beliefs can influence how you feel about medical treatments and what quality/dignity of life means to you. What would you want those caring for you and anyone you choose to be your health care agent to know about your beliefs?

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What abilities would be so critical to your life that you could not imagine living without them (example: ability to interact with people, ability to eat, ability to care for yourself, etc)?

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Name ____ Date ____________________

Understanding your feelings about how long you would want your life preserved or prolonged is important to those caring for you and to your health care agent(s). Think about what you would choose in the following situations:

Consider if you were in an automobile crash that left you with a head injury. Your vital organs can continue to work with medical care for years. What would your goals of treatment be if you permanently lost the ability (ie: in a coma or a persistent vegetative state) to know who you were, who you were with, or where you were?

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Consider if you had a stroke and could no longer communicate, or if you are diagnosed with dementia or Alzheimer's. What kind of mental or physical conditions would make you think that medical treatment should no longer be used to prolong your life?

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If you were pregnant what would be your feelings about medical treatment for yourself and your baby if you were not going to recover and were unable to communicate?

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Consider if you had a terminal disease – some treatments can extend your life but may also leave you unable to communicate or interact with your loved ones. What preferences and goals would you have for your care?

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If it was determined that your time remaining is in the final days to weeks, what would be most important to you?

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Name ______________________________________ Date ___________________

Is there a time when it would be okay to shift from focusing on providing all possible treatments to focusing on comfort alone? (i.e. no hope for recovery, vegetative state, etc.)

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If a choice is possible and reasonable, where would you prefer to receive care in your final days?

◯ At home
◯ At a hospital
◯ At a nursing home/care facility
◯ Hospice - in home
◯ Hospice residence

What are your thoughts on donating organs, tissues, or other body parts?

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What are your thoughts on autopsy?

◯ If an autopsy helps my loved ones to understand the cause of my death or assist them with their own healthcare decisions, I would want an autopsy done.

◯ I would not want an autopsy performed unless required by state law.

MY GOALS FOR HEALTH CARE TREATMENTS

Think about the following situations and treatment options and note what your choices are. Health care treatment will always include maintaining your comfort, personal hygiene and human dignity.

My choice for pain control:

Consider the following goals for yourself regarding pain control. **Choose ONE OPTION:**

◯ Maximum pain control even if I may not be awake or interacting with loved ones often.

◯ Moderate pain control- I want to be able to interact at times with my loved ones even if that means I have some pain.

◯ Minimal pain control- I want to be able to be aware of surroundings and interact with my loved ones even if that means I am in pain.

My choices for Life-Supporting or Life-Prolonging Treatments

Consider the following possible situations and the use of life-supporting or life-prolonging treatments. Choose one of the following options:

1. I would **want all life support/prolonging treatment.**
2. I do **not want any** life support/prolonging treatment. I know I will be supported with comfort and palliative care treatments.
3. I want my **Health Care Agent and my Providers to decide** based on my goals, values, and the benefits and burdens of the treatments considered.

Life-Supporting or Prolonging Treatments	My Choice
If I have a reasonable chance of recovering **both** physically and mentally. To me this means _________ % chance of recovery.	○ I would **want all life support/prolonging treatment** ○ I do **not want any** life support/prolonging treatment ○ I want my **Health Care Agent and my Providers to decide** based on my goals, values, and the benefits and burdens of the treatments considered.
If I can no longer move independently but I can socially relate to those I care about	○ I would **want all life support/prolonging treatment** ○ I do **not want any** life support/prolonging treatment ○ I want my **Health Care Agent and my Providers to decide** based on my goals, values, and the benefits and burdens of the treatments considered.
If I am not able to relate socially to those I care about	○ I would **want all life support/prolonging treatment** ○ I do **not want any** life support/prolonging treatment ○ I want my **Health Care Agent and my Providers to decide** based on my goals, values, and the benefits and burdens of the treatments considered.
If I have little or no chance of doing everyday activities I enjoy	○ I would **want all life support/prolonging treatment** ○ I do **not want any** life support/prolonging treatment ○ I want my **Health Care Agent and my Providers to decide** based on my goals, values, and the benefits and burdens of the treatments considered.
If I can live a longer life no matter what my physical or mental abilities are	○ I would **want all life support/prolonging treatment** ○ I do **not want any** life support/prolonging treatment ○ I want my **Health Care Agent and my Providers to decide** based on my goals, values, and the benefits and burdens of the treatments considered.
If I have a terminal illness and treatment will only prolong when I die	○ I would **want all life support/prolonging treatment** ○ I do **not want any** life support/prolonging treatment ○ I want my **Health Care Agent and my Providers to decide** based on my goals, values, and the benefits and burdens of the treatments considered.

Name ____ Date ____________________

Life-Supporting or Prolonging Treatments	My Choice
If I have severe and permanent brain injury and there is little chance of regaining consciousness	○ I would **want all life support/prolonging treatment** ○ I do **not want any** life support/prolonging treatment ○ I do want my **Health Care Agent and my Providers to decide** based on my goals, values, and the benefits and burdens of the treatments considered.
If I have severe dementia or confusion and my condition will only get worse	○ I would **want all life support/prolonging treatment** ○ I do **not want any** life support/prolonging treatment ○ I want my **Health Care Agent and my Providers to decide** based on my goals, values, and the benefits and burdens of the treatments considered.

Comments

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My choices for medical treatments

Consider the following medical treatments that are used to support or prolong life. Most medical treatments can be tried for a period of time and then stopped if they are not helping. You should talk with your health care provider to make sure you understand how well the treatments will work for you given your current and future health conditions. Ask your health care team for the patient information sheets on each of these topics. They have important information on the benefits and burdens of these treatments and can help you consider your feelings and choices.

As you consider each treatment option, choose one of the following statements

1. I **would choose this treatment**. I understand there may be burdens associated with the treatment and am willing to accept those so my life can be sustained and/or prolonged as long as possible.
2. I would **choose this treatment in these circumstances**: Please explain when you would choose the treatment (for example only when you have a chance of recovering physically and/or mentally or to treat a reversible illness or injury) and how long you would like to try the treatment before stopping; for example if it is found to be a burden to you or no longer helpful.
3. I **would not choose this treatment**. I know I will be supported with comfort and palliative care treatments.

Name ____ Date ____________________

Ventilator-Respirator-Breathing Machine. See the "Help with Breathing" information sheet for more information. A ventilator is a machine attached to a tube in your throat and used to breathe for you when you cannot.

◯ I **would choose** this treatment.

◯ I would **choose this treatment in these circumstances**:

When ____

How long? ____

◯ I would **not choose this treatment**.

Artificial Nutrition and Hydration. See the "Hydration and Nutrition" information sheet for more information. Used to help your body receive artificial feedings through a tube placed in your stomach or down through your nose.

◯ I **would choose** this treatment.

◯ I would **choose this treatment in these circumstances**:

When ____

How long? ____

◯ I would **not choose this treatment**

Cardiopulmonary Resuscitation (CPR). See the "CPR" information sheet for more information. CPR includes breathing into your mouth, pressing on your chest, and using medicine and electrical shocks to get your heart working if it stopped beating.

◯ I **would choose** this treatment.

◯ I would **choose this treatment in these circumstances**:

When ____

How long? ____

◯ I would **not choose this treatment**

If you are adding this document to a new health care directive print your name and the date at the bottom of each page. Note on your health care directive you are attaching these pages.